

studies show that appendicular mass and even perforated appendicitis can be managed conservatively. We investigated whether appendectomy during the stage of mass formation carries any extra morbidity compared to surgery for non-mass forming appendicitis.

Patients and Methods: In hospital stay and post-operative complications of patients with intra-operative finding of appendicular phlegmon were compared with those not having appendicular mass over a period of 5 years.

Results: Between July 2004 to December 2009, 61 patients with appendicular mass and 363 patients with acute appendicitis / perforated appendicitis without appendicular mass were operated upon. Complications in appendicular mass group were wound infection (22.9 %), wound dehiscence (9.83%) and incisional hernias (3.27%) while in the group without appendicular mass they were wound infection (7.1%) and wound dehiscence (3.03%). There was no mortality in either group.

Conclusion: Operating on patients with appendicular mass is safe, as it doesn't entail any additional morbidity except for increased rate of wound infection and increased mean operating time, and is life saving in cases associated with perforation and peritonitis.

0740 IMPROVING THE QUALITY OF OPERATION NOTES IN GENERAL SURGERY

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Aim: Adequate documentation is a professional requirement, as stated in the RCSEng 'Good Surgical Practice' guide 2008. The NCEPOD 2009 (Death in Acute Hospitals: Caring to the end?) reported that poor documentation is commonplace in all aspects of management of surgical patients. We aimed to investigate whether operation note completion could be improved by displaying the RCSEng guidelines in the operating theatre.

Method: 72 operation notes were reviewed. 35 were reviewed prior to distribution of the RCSEng guidelines, 37 afterwards. Three assessors independently reviewed the notes and assessed them according to the guidelines.

Results: Prior to distribution of the guidelines, post-operative instructions were complete in 34% (12/35). Following the intervention, this improved to 97% (36/37), $p < 0.001$. Only 77% (27/35) of notes in the first group were deemed sufficient to allow continuity of care, this subsequently increased to 97% (36/37), $0.001 < p < 0.01$ (Chi-Squared test).

Conclusions: Adequate completion of operation notes is essential for good clinical care. There is evidence of widespread deficiencies in this area with potential adverse implications. We have demonstrated that with a simple intervention the quality of operation notes can be significantly improved and suggest that teaching on completion of operation notes be included in surgical training.

0741 ONE YEAR AFTER THE ETWD: IMPACT ON TRAINEE OPERATIVE EXPERIENCE

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Aims: The EWTd limited junior doctor working hours to 48 hours per week from August 2009. This study assesses the impact of this legislation on the operative experience of general surgical trainees in one institution after one year.

Method: Data was obtained from a prospectively gathered operative database used to generate contemporaneous operation notes. Grade of operating surgeon and assistant(s) for all elective and emergency general and vascular surgical operations performed in July 2010 in our institution was recorded. A data set from July 2009 was obtained for comparison. Data was analysed using proportions and the chi-square test.

Results: There is no statistically significant reduction in trainees' first operator experience. Trainees performed 43.4% of operations in July 2010 and 50.7% in July 2009 ($p = 0.03$). There is a significant increase in trainees participating as assistants ($p < 0.01$). Scrub practitioners are involved in a minority of procedures.

Conclusions: There is a trend towards reduced trainee operative experience after the introduction of the 48 hour week. Since August 2009, surgical trainees in our institution are not expected to attend out-patient clinics or endoscopy sessions to facilitate operative exposure. This may no longer be adequate to ensure acceptable levels of experience for safe surgical training.

0743 SENTINEL LYMPH NODE MICROMETASTASIS – SHOULD PATIENTS PROCEED TO AXILLARY LYMPH NODE CLEARANCE?

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Aim: Sentinel lymph node biopsy offers a minimally invasive approach to the assessment of the axillary lymph node status in patients with breast cancer. Treatment of patients with a tumour deposit $< 2\text{mm}$ (micrometastasis) remains controversial. The aim of this study was to determine if patients with micrometastasis should undergo axillary lymph node clearance.

Method: This is a retrospective review of all patients undergoing sentinel lymph node biopsy within our unit from June 2006 to December 2010. Sentinel node characteristics, tumour details and clinical outcome were recorded prospectively.

Results: 378 patients underwent sentinel lymph node biopsy (median age – 60 years, range 28–83 yrs). 104/378 patients had a positive sentinel lymph node biopsy. 19/104 patients had evidence of micrometastasis. 17 patients with micrometastasis underwent axillary node clearance. Two patients were offered adjuvant therapy.

4/17 patients had positive axillary lymph nodes after the second procedure. There were no specific tumour characteristics predictive of non sentinel lymph node metastasis in these patients.

Conclusion: Almost a quarter of patients with micrometastasis had evidence of further lymph node involvement. The presence of micrometastasis is a good predictor for non sentinel lymph node metastasis and patients should undergo axillary clearance.

0746 END OF LIFE BLOOD TRANSFUSION IN PATIENTS WITH COLORECTAL CANCER – IS THERE A NEED FOR GUIDELINES?

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Aims: While blood transfusion for incurable colorectal cancer patients may improve symptoms in patients with anaemia, stopping transfusion as part of withdrawal of active care is often unconsidered. This presentation reports blood transfusion in the last four weeks of life.

Methods: Retrospective review of data on colorectal cancer patients was cross-referenced with the regional blood transfusion database. Information on patient age, sex, and curative/palliative management was collected. Group and save, cross-match and transfusion status in the 4 weeks leading up to death were noted.

Results: Between 1 January 2007 and 31 December 2008, 483 colorectal cancer patients were identified of whom 390 underwent surgery. At follow-up 31 Dec 2010, 120 patients had died. Of these 76 had undergone prior curative resection and 44 conservative treatments. 10 patients in the curative surgery group and 5 in the conservative management group were transfused 4.5 (2–20) units mean (range) within 4 weeks of death. Worrisomely 22 units were administered within 7 days of death and 10 units administered within 48 hours of death.

Conclusions: While overall transfusion rates in the later stages of care appeared acceptable, the appropriateness of transfusing patients with end stage disease in a palliative setting in whom other forms of active treatment has been withdrawn, is questionable.

0748 THE ROLE OF SPECIALIST NURSE CONSENTING IN CLINIC AND SURGEON EDUCATION IN REDUCING DAY-OF-SURGERY CONSENT RATES FOR ELECTIVE ENT SURGERY

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